Ontario

Reinvestment Strategy for Children and Youth

Ministry of Community and Social Services
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Introduction[1]

Making Services Work for People and the reinvestment strategy

The framework for reshaping social services in Ontario is set out in *Making Services Work for People.* This framework applies to both the Children's and Developmental Services sectors.

Making Services Work for People requires each local system of services to provide essential supports to those in greatest need, and to provide investment supports to reduce or eliminate the need for future services.

One goal of the Ministry of Community and Social Services is to increase the use of investment supports/services, to prevent or reduce the need for essential and long-term government supports. A key reshaping goal is that families and individuals will receive supports earlier, before they are in crisis or the family breaks down, and/or before more intrusive or more expensive supports are required. Therefore, the Ministry will reinvest some resources in effective prevention, early intervention and developmental supports/services for designated groups of children, youth and adults.

The Ministry's reinvestment strategy is contained in two documents: The *Reinvestment Strategy for Adults with a Developmental Disability,* and the *Reinvestment Strategy for Children and Youth.*

Purpose

The purpose of the reinvestment strategy is to reduce avoidable personal and social costs to families and communities and the financial costs to government that arise when children, youth and adults require long-term or intrusive, expensive services.

- **Adults with a developmental disability**
  The adults identified in *Making Services Work for People* as the focus for reinvestment are adults with developmental disabilities who need supports to help them live independently. Research is ongoing in the Ministry on the kinds of effective early intervention and developmental supports which enable an adult with a developmental disability to increase his or her level of independence. The purpose of the *Reinvestment Strategy for Adults with a Developmental Disability* is to provide details which will assist Area Offices in developing local reinvestment plans.

- **Children and youth**
  Research shows that certain services and supports, when provided to families with young children, or youth at risk, will help keep the children, youth and their families from requiring more costly, intrusive or longer term services. For some children, particularly those with a developmental disability, the prospect for future need of government-funded supports may continue to exist. The

1 This Introduction, with minor adjustments, appears in both the *Reinvestment Strategy for Adults with a Developmental Disability,* and the *Reinvestment Strategy for Children and Youth.*

purpose of this document is to specify effective supports/services that research shows could decrease the overall lifetime supports that might otherwise be required by each of the groups identified for reinvestment.

Vision

Designated groups of children, youth and adults will have access to a system of effective supports/services to:

- promote healthy growth and development,
- prevent social, emotional and behavioural problems,
- maintain maximum independence possible, and
- help achieve full participation in the community.

Reinvestment, investment and essential supports

The expectation in *Making Services Work for People* is that the social service system will move toward greater emphasis on investment generally. Investment services are those focussing on prevention, early intervention and developmental supports. In addition, through the Ministry's reinvestment strategy, resources are to be increased for certain identified effective investment supports for identified groups of children, youth and adults.

Local systems of services must ensure that essential supports are funded. Once essential supports are covered, reinvestment funds may only be used for the supports and services identified in The *Reinvestment Strategy for Children and Youth*, and in The *Reinvestment Strategy for Adults with a Developmental Disability*. The reinvestment resources may only be used for the groups designated for reinvestment in the *Making Services Work for People* document. On the other hand, existing essential and investment services may continue to be directed to other groups of high risk or high needs children, youth and adults, and may include other types of services as appropriate.

Some service providers already provide one or more of the effective services, specified in the reinvestment documents, as either investment or essential services. It is possible that such service providers could receive additional funds to provide the same service for one (or more) of the groups selected for reinvestment. Thus, some service providers may provide the same service (for example, respite care) as an **essential service** to high needs families, as an **investment service** to families outside the reinvestment groups and as a **new or expanded investment service to families in the selected reinvestment group(s).**

Reinvestment and other funders

The reinvestment strategy operates within the context of the nine Ministry goals to reshape services. The eighth and ninth goals are particularly relevant to how reinvestment will proceed:[2]

2 *Making Services Work for People*, p. 6.

8. Families and individuals will receive services that lead to less reliance on government-funded services. Services funded by the Ministry of Community and Social Services will encourage cooperation with other community supports, such as volunteer organizations, charitable foundations, religious institutions and businesses, as well as informal networks of family and friends.

9. Families and individuals will receive a coordinated set of services funded by the Ministry of Community and Social Services and other funders when necessary. *Making Services Work for People* will result in local systems of services where individuals and families requiring both MCSS-funded services and services of other funders find it easier to receive a coordinated set of services. Local services systems will involve partnerships with other funders, including health services, school boards, youth justice partners, municipalities, charitable organizations, religious organizations and businesses.

These goals indicate that while MCSS will reinvest some funds in prevention, early intervention and developmental supports, this reinvestment will primarily proceed in partnership with other funders, volunteers and with families and consumers. For example, reinvestment funding for **prevention** supports **must** be in an integrated model, with supports of other funders or the voluntary sector. Integration with other funders is not required for early intervention and developmental supports. However, in many cases partnerships with other organizations promote the most efficient and effective use of these funds.

The *Reinvestment Strategy for Children and Youth*

This document provides information about the reinvestment strategy for children and youth. This document identifies a menu of 9 types of effective supports/services and their 6 key system features, and where to locate the supports/services. The recommendations are based on what is known to be effective in preventing or reducing the need for long term or intrusive, expensive supports/services. Based on local priorities, Area Offices and local planning groups are to choose exclusively from among the menu of effective supports/services when planning which organizations or activities will receive increased resources through reinvestment. The advice is flexible, and intended to assist each local planning process to adapt and develop a system tailored to its local area.

Focus

In the past the major efforts of the Ministry of Community and Social Services have focused on providing essential services to children and youth in greatest need. Such children and youth already have substantial physical, emotional, social or behavioural problems or conditions that require major interventions.

The reinvestment strategy focuses on identified groups of children and youth who are:

1) at risk of developing problems (prevention), or

2) just beginning to show through their behaviour or symptoms that they are starting to develop a problem (early intervention), or

3) developmentally delayed (developmental) and who need appropriate supports/services to avoid long-term or intrusive, expensive services.

Prevention as a goal: **All** MCSS supports/services, both essential services and investment services, have prevention as a goal. That is, **all** MCSS services work to prevent clients from requiring more expensive, intrusive and long-term services. Or more positively, all MCSS services work to enhance the ability of clients to develop and function as healthily and independently as possible, regardless of their level of need.

Prevention as a service: The reinvestment strategy focuses on prevention as a support/service. These supports/services are specifically designed for designated groups of children and youth who are **at risk** of poor outcomes which require long-term or intrusive services, but these children and youth are not yet exhibiting specific behaviours or symptoms. Risk factors are characteristics of the child or youth (such as physical health or coping skills), or characteristics of their environment (such as poverty or family violence) and that research has shown puts these children and youth at greater risk of poor outcomes (such as poor school performance, mental disorders, child abuse, anti-social behaviour, low birth weight, substance abuse).

Early intervention supports/services: apply to children who personally exhibit behaviours or symptoms indicating they are just starting on a course that could require expensive, intrusive or long-term services. Early intervention supports/services are provided early to prevent the anticipated long-term deviations from healthy development.

Developmental supports: apply to children with identified developmental delays. Developmental supports are provided to assist the child to achieve his/her potential, or to prevent loss of function.

The Ministry will focus its reinvestment on effective prevention, early intervention and developmental supports/services for specific groups of children and youth:

For purposes of reinvestment, the prevention focus is:

- families with children under six who live in neighbourhoods with high rates of poverty and social services utilization,
- mothers and expectant mothers who are under age 20 with low incomes, and their children,
- children and youth whose parents have developmental disabilities,
- children and youth whose parents have serious problems with substance abuse or mental disorders,
- children and youth whose parents are in prison,
- children and youth in families where violence has occurred, and
- children and youth in families where child protection services have been required.

These children and youth are at risk because of aspects of their environment. The children and youth may not personally have any abnormal behaviours or symptoms. However, their family or community puts them at risk of poor child development.

For purposes of reinvestment, the early intervention and developmental focus is:

- children under six years of age with developmental delays,
- children under six years of age with aggressive behaviour, and
- children under six years of age in the early stages of developing an emotional or behavioural disorder.

These children are at risk because of personal, individual behaviours, symptoms or conditions that they are exhibiting, which indicate that they are on a course that could require long-term or intrusive, expensive services.

Rationale

The following outlines why certain risk factors are a priority for reinvestment:

1. **Young children, ages birth - six years:** See bibliography: 20, 24, 25, 32, 35, 81, 89

   The Ministry has identified the period from infancy to age six, because research demonstrates this is a period critical to brain and nervous system development. The quality of nurturing during this period is crucial because the cortex of the brain is undergoing its most rapid development. Very early experiences have lifelong influences on language and cognitive development, coping skills, social behaviour and problem-solving in later life. Research also shows the child's transition from home to primary school can set the stage for success in school for the succeeding years.

2. **Neighbourhoods with high rates of poverty and social service use:** See bibliography: 6, 11, 23, 26, 31, 34, 62, 63, 81 83, 86, 88, 105

   Persistent and concentrated poverty, present in some Ontario neighbourhoods, is in itself a marker for multiple risk factors which will have a strong negative impact as children grow. The families and children with multiple risk factors generally require greater use of social services. Research shows prevention, early intervention and developmental support can reduce risk factors and negative outcomes in these neighbourhoods.

3. **Mothers and expectant mothers under age 20 with low incomes, and their children:** See bibliography: 12, 44, 45, 46, 82, 90, 92

   The Ministry identified this risk factor because the children of mothers under age twenty are at risk for poor outcomes (such as low birth weight, abuse, poor school performance), even if they are not living in low income neighbourhoods. Young mothers themselves are at risk for long term social assistance dependence, and their children are at risk of becoming a second generation that grows up and requires social assistance.

4. **Children and youth whose parents have serious problems with substance abuse or mental disorders, are in prison, or where family violence or child abuse/neglect has occurred:** See Bibliography: 1, 2,3, 17, 18, 37, 57, 106

   Children and youth in these types of families are at risk for problems with attachment, ability to parent and overall family and environmental deprivation. These factors often lead to more serious and entrenched types of poor outcomes. These problems frequently begin early and are very difficult to overcome. The children and youth in this category were selected – even though they may not be exhibiting any symptoms – because the research shows these children and youth are at very high risk for poor outcomes (such as poor school performance, conduct problems, depression, reduced developmental potential) by virtue of their parents' or family's characteristics alone.

5. **Children and youth whose parents have developmental disabilities:** See bibliography: 49, 50, 98,99

   Children and youth whose parents have developmental disabilities may face a unique set of challenges. The children and youth in this category were selected because research shows the may be at risk for reduced developmental potential, as well as other physical, cognitive, behavioural, social and emotional difficulties.

6. **Children under six with aggressive behaviour or in the early stages of developing an emotional or behavioural disorder:** See bibliography: 19, 38, 44, 53, 71

   The Ministry identified these characteristics because research shows these are often the signals that increasingly severe problems will appear in the future.

7. **Children under six with developmental delays:** See Bibliography: 15, 56, 64, 66, 70, 73

   Research shows that young children whose development is showing signs of delay are at risk of not meeting their developmental potential. Children with developmental delays are also at risk of child abuse, learning disabilities and chronic health problems.

It is clear that an adverse environment can compromise brain function, overall development, level of functioning and increase the risk of developing a variety of physical, cognitive, behavioural, social and emotional difficulties. It can also add to developmental delays, or prevent children from reaching their potential. Some adverse effects may be irreversible.

There is good evidence to show that poor outcomes in children and youth can be substantially altered to be less negative through increased social and physical supports to children, youth, families and communities.

Mounting research evidence shows prevention, early intervention and developmental supports/services can effectively:

- reduce the occurrence of poor child and youth outcomes,
- help children to achieve their potential, and
- maintain the integration of children with disabilities in society.

Through its reinvestment the Ministry intends to build a system of effective supports and services for children and youth in the designated groups. The reinvestment funds can be used to support any of the nine types of effective supports/services with six key system features. It should be noted that none of the nine supports/services will be effective without the six key system features. It is the system features that are key to making the services effective.

Effective supports/services

Nine types of effective prevention, early intervention and developmental supports/services emerge from research reviews that cross disciplines and sectors:

1. **Home visiting**
   See bibliography: 13, 29, 31, 42, 43, 59, 60, 67, 69, 81, 82, 83, 91, 92, 102, 113, 117
2. **Flexible continuum of child care**
   See bibliography: 11, 22, 29, 30, 61, 64, 66, 70, 77, 78, 84, 85, 86, 93, 95, 102, 104, 105, 111, 126
3. **Supports to the primary schools**
   See bibliography: 10, 92, 111
4. **Family support, education and community development**
   See bibliography: 4, 7, 33, 45, 46, 56, 57, 73, 86, 94, 99, 100, 102, 115, 116, 118, 122, 125
5. **Mentoring**
   See bibliography: 5, 51, 52, 53, 54, 58, 69, 101, 112
6. **Support groups**
   See bibliography: 16, 35, 54, 102, 117, 118, 122
7. **Supports to stay in school**
   See bibliography: 12, 54, 55, 58, 110
8. **Recreation**
   See bibliography: 24, 37, 38, 39, 40, 41, 62, 63, 71, 80, 87, 88, 89, 90
9. **Casework and clinical practices**
   See bibliography: 8, 74

Research shows these supports/services can reduce a variety of negative outcomes such as mental disorders, child abuse, poor school performance, reduced developmental potential and conflict with the law. These nine supports/services are effective, regardless of whether the focus is prevention, early intervention or developmental supports. The difference is whether the support/service focuses solely on children who personally have symptoms, behaviours or conditions indicating they are on a path that could worsen (early intervention and developmental), or whether the focus is on children at risk, but not yet exhibiting symptoms (prevention).

Ideally, each local planning process will ensure the nine types of effective supports/services are available for the selected groups of children and youth. These effective supports/services are most similar to Ministry-funded Better Beginnings programs, family resource centres, child care, infant development, special services at home programs, and some prevention and early intervention services funded through children's mental health centres, child welfare agencies and other children's agencies.

There is one caution about research on effective services. The findings of the research tend to be similar in most European and North American countries. There is very little published research that is directly applicable to the kinds of ethno-cultural or Aboriginal groups found in Ontario. However, community consultations with First Nations and Aboriginal communities in Ontario around Aboriginal healing and wellness, child care and youth suicide highlight the need for services similar to the ones set out in this document. If local planning focuses on ethno-cultural or Aboriginal groups for prevention and early intervention, the recommended approach is to discuss the types of effective services presented in this document with community leaders, parents and service providers. Jointly determine whether it might be appropriate to begin with these services, and be sure to tailor the services to local needs and desires.

Each of the nine effective supports/services is described below.

1. Home visiting: See bibliography: 13, 29, 31, 42, 43, 59, 60, 67, 69, 81, 82, 83, 91, 92, 102, 113, 117

The research literature has demonstrated that home visiting is effective when provided by nurses or lay home visitors (who are well-trained community residents). Both the nurse and lay home visitors receive training in stages of child development, crisis counselling, assessing needs and linking with other services. Home visiting begins as early as possible during pregnancy or the identification of a behavioural problem or a developmental delay.

Home visiting to designated groups of families with young children continues through pregnancy for at least the first two years of the baby's life, and perhaps longer depending on the level of risk and need for the family. Home visiting to families with older children and youth begins when a problem is identified and lasts until the problem is resolved or home visiting is no longer needed or appropriate.

Home visiting programs primarily address the basic elements of providing a safe, secure and nurturing home by reducing stress on the children, youth and parents. The home visitor also provides the family with learning opportunities about family functioning, healthy growth and development, including infant and toddler development, behaviour management and living skills. Home visitors are trained in case management, assessment and counselling.

The visits are not focused on a single issue. They address the issues of concern to the family. If a family is having difficulty meeting their basic needs, the home visitor assists in linking the family to food, housing and clothing supports. If there is a problem with, for example, family violence or mental health, the visitor assists in linking to appropriate supports/services in those areas.

An important part of home visiting is helping the child, youth or family build in social support, through extended family, local support groups and recreation.

2. Flexible continuum of child care:

See bibliography: 11, 22, 29, 30, 61, 64, 66, 70, 77, 78, 84, 85, 86, 93, 95, 102, 104, 105, 111, 126

There are many child care supports and family resource centres funded through the province, municipalities, faith communities and other organizations. To be effective as prevention, early intervention and developmental supports/services, the many child care supports need to form a system of comprehensive, integrated supports/services that are of high quality and meet the needs of the children and families that use them. The reinvestment strategy permits the Ministry to enhance child care supports/services, to make them effective for designated groups of children and families.

The purpose of effective child care supports/services is to reduce child-rearing stress on the parent(s), and to improve the opportunities for parental care and stimulation activities for children.

Parents of children in the designated groups need a variety of child care supports/services to help them to raise healthy babies and young children.

The range includes drop-in centres, respite care[3], infant and toddler development, behaviour management and life skills development, parent/child playgroups, home-based care as well as centre-based care. To be effective, this range of child care supports/services needs to be provided at hours that meet the needs of the parents, which includes evening, weekend and before/after school supports, in addition to services provided during traditional work hours. Effective prevention and early intervention and developmental child care supports/services are supervised by trained early childhood educators, and implemented by trained volunteers and para-professionals.

Specialized supports/services within an integrated child care setting is a very important part of early intervention for young children with aggressive behaviour, reduced developmental potential or early signs of other mental disorders. This requires a close association among those involved with the family, such as child care staff, developmental support workers, key health and mental health professionals and other services, such as speech and language.

3. Supports to primary schools:

See bibliography: 10, 92, 111

The transition to primary school is a very important step in a child's life. Effective prevention, early intervention and developmental programs that can improve the chances of success during this transition include:

- before and after school child care and recreation programs,
- additional playground supervision, especially when combined with conflict resolution and cooperative play activities,
- in-class supports to the teachers to provide additional individual attention or small group work,
- outreach to high-needs or chaotic families,
- links with child care programs,

3 Family relief/respite is an effective service for both adults with developmental disabilities and for children. As such, it may represent a continuum of support throughout the life of a person with a developmental disability.

- nutrition programs, and
- supports to parent participation in school planning.

These programs have been successful when supervised by a coordinator who maintains close links with the school principal and teachers, and implemented by trained community-based para-professionals and volunteers. Effective programs reduce risks by involving parents and community leaders in schools, and demonstrating that schools are a safe and welcoming place for children and parents. These supports help ensure families remain intact and children achieve their full potential.

4. Family support, education and community development:

See bibliography: 4, 7, 33, 45, 46, 56, 57, 73, 86, 94, 99, 100, 102, 115, 116, 118, 122, 125

Family support, education and community development programs include:

- all kinds of support groups (of parents, fathers, youth, single mothers, children of divorced parents),
- parent training,
- behaviour management and infant development,
- community advocacy groups (such as Neighbourhood Watch and tenants associations),
- self-help activities (such as clothing exchanges and cooperative food purchasing), and
- a host of neighbourhood enhancement activities, such as playground, parks and community garden development.

There is recent evidence that resilience – the ability to bounce back, to recover strengths and spirits quickly – can apply to communities as well as individuals. Resilient communities have patient and persistent community leaders who have the ability to pull people together, including those who are usually left out, and build cooperative and collaborative approaches. The focus is on building trust, finding a shared sense of commitment to community, strengthening social institutions at the community level and strengthening local commitment to shared goals.

Supervised by a coordinator and implemented by trained para-professionals or volunteers, with expertise provided by professionals as needed, these programs are tailored to the community's needs and desires. Family support, education and community development programs are sometimes delivered by professionals (as in some parent training programs), but more often these programs are run by parent volunteers or community-based para-professionals. These programs often provide information and education on parenting and child development, but they also directly address self-help and local leadership development, which are very important issues in high-risk communities.

5. Mentoring: See bibliography: 5, 51, 52, 53, 54, 58, 69, 101, 112

The concept of mentoring arises from the studies of children who thrive despite very poor environments. The research from this area shows that high-risk children and youth who do well under those circumstances often had a stable caring individual who provided nurturing and support. The goal of mentoring programs is to establish a long-term stable relationship between a child or youth with another caring youth or adult. Sometimes the mentoring arrangement is formally established as part of an ongoing

children's mental health, child welfare agency or developmental support plan. Sometimes the service is provided, less formally, by groups such as Scouts or Boys/Girls Clubs, or individuals such as teachers and coaches.

6. Support groups:

See bibliography: 16, 35, 54, 102, 117, 118, 122

Children and youth whose families are unstable and/or dysfunctional due to substance abuse or mental disorders, or where there has been family violence and abuse/neglect often benefit from participating in support groups of other people with similar stresses. The groups are often led by trained professionals, or skilled and experienced volunteers and para-professionals, who can provide the safety and security required, and facilitate the group participation in an appropriate manner. Children and youth of parents with developmental disabilities can also benefit from participation in support groups.

7. Supports to stay in school:

See bibliography: 12, 54, 55, 58, 110

Supports to stay in school are very important to preventing long-term dependence on social assistance for both the teen mother and her infant/toddler, as well as for youth in families where there is family violence or abuse/neglect, or where the parents are incarcerated, substance abusers or have mental disorders. The research shows teen mothers and other youth who graduate from high school and post-secondary education are much less likely to require social assistance and are mentally much healthier. Over the long-term, the children of teen mothers are more likely to also do well in school if their mothers furthered their education. These supports ideally need to be available to the teen mother and high risk youth, even if they have dropped out of school for a period of time.

8. Recreation:

See bibliography: 24, 37, 38, 39, 40, 41, 62, 63, 71, 80, 87, 88, 89, 90

Research shows high quality, developmentally appropriate physical and recreational activities can provide positive physical and mental health benefits, and improvements in family and social interaction as well as academic performance. An Ottawa program was able to save the costs of the program through reduced vandalism, charges against juveniles and false fire alarms. There appears to be particularly strong links between physical activity and positive mental health, and among motor development, brain development and social and cognitive skills in very young children.

Physical and recreational programs provide children and youth with the opportunity to develop skills and build their self-esteem. Recreation programs also provide parents and other family members of high-risk children and youth with some much-needed personal free time while the recreation programs are under way.

There are positive outcomes associated with both formal and informal programs. Specialized recreation programs for high-risk youth, such as young offenders and youth abusing substances, require careful leader selection and more leadership training to be effective. Some research shows that youth in low income communities may have been unable to access equipment and facilities. Recreation programs operating in these circumstances often concentrate on skill development for the various types of physical activities, to boost comfort and confidence to play.

9. Casework and clinical practices: See bibliography: 8, 74

Early intervention for children under six years of age with aggressive behaviour or the early stages of developing an emotional or behavioural disorder sometimes require casework and clinical practices, such as assessment, counselling and referrals to other specialties such as speech and language supports or marital therapy for the parents. Young children with developmental disabilities may also benefit from casework and clinical practices. Although casework and clinical practices are more closely aligned with essential supports, they can be critical and effective as early intervention investment supports too.

The kinds of casework and clinical practices that are effective will vary according to many factors, such as age, gender, type of problem and available resources.

- In general, each agency and staff member is expected to be knowledgeable about best practices for the types of clients within their mandate. This document does not specify individual kinds of effective casework and clinical practices, because there are too many to cover.
- The Ministry is supporting research to identify best practices for well-known types of major problems, including young offenders, young children with conduct problems and youth at risk of out-of-home placement. The reports will be ready shortly and they document effective early intervention casework and clinical practices for these groups of children and youth.

It is worth noting that early intervention casework and clinical practices must sometimes be intensive. There is a misconception that early intervention consists solely of modest to moderately intensive services. However, there are times when effective early intervention will consist of short-term out-of-home placement, or intensive clinical work. The main feature of effective early intervention casework and clinical practices is that they are offered early in the development of a problem. If the problem has been in existence for a long time, then they are no longer early intervention, but have progressed to become treatment.

Key system features

The research shows that the nine effective supports/services will **only** be effective if they are implemented with the following six system features.

1. **Holistic**
   See bibliography: 4, 14, 22, 37, 39, 42, 58, 65, 70, 82, 84, 86, 92, 96, 102, 114, 117, 122

2. **Ensure access**
   See bibliography: 4, 37, 42, 45, 46, 61, 62, 84, 85, 86, 92, 100, 102, 114, 116, 117, 118, 122

3. **Involve parents/youth/community leaders**
   See bibliography: 4, 37, 45, 84, 85, 87, 92, 94, 96, 100, 102, 114, 117, 118, 122

4. **Tailor to the local community**
   See bibliography: 4, 37, 45, 59, 84, 85, 86, 92, 94, 95, 100, 102, 114, 116, 117, 118, 122

5. **Integrate supports/services**
   See bibliography: 4, 37, 86, 92, 94, 100, 102, 114, 117, 118, 122

6. **Create linkages and partnerships**
   See bibliography: 4, 37, 86, 92, 94, 100, 102, 114, 116, 117, 122

Each local planning process should ensure the six key system features are implemented as part of each of the previously mentioned effective supports/services:

1. Holistic: See bibliography: 4, 14, 22, 37, 39, 42, 58, 65, 70, 82, 84, 86, 92, 96, 102, 114, 117, 122

Effective prevention, early intervention and developmental supports/services systems see the child or youth in the context of the family and the family in the context of the community. Effective supports/services are flexible in defining work to meet the broad, related, but often unspoken needs, of children, youth and their families.

The key system feature of being "holistic" applies to all the types of effective prevention, early intervention and developmental supports/services. It has clearly been demonstrated that for the designated groups, single-focus programs are not effective. Children and youth in the designated groups frequently have multiple problems, or multiple needs. These cannot be effectively addressed without holistic supports/services. If funds are limited, it is better to provide just a few of the effective supports/services that are holistic, rather than spreading the funds so thinly across more supports/services that they cannot be holistic.

There are common characteristics of staff who work in holistic programs. They find ways to adapt or circumvent traditional professional and bureaucratic limitations when necessary to meet the needs of those they serve. No one says, "this may be what you need, but helping you get it is not part of my job or outside our jurisdiction." Staff take special pains to maintain continuity in relationships, especially at critical life milestones. While referrals are an important part of holistic services, most staff in effective programs use them sparingly. Continuity is valued in holistic services, and if it cannot be delivered by one individual, it is maintained by a small, committed team.

2. Ensure access: See bibliography: 4, 37, 42, 45, 46, 61, 62, 84, 85, 86, 92, 100, 102, 114, 116, 117, 118, 122

It is often difficult for the designated groups to obtain access to programs. High-risk families frequently do not have cars or money for transport or child care; sometimes the programs are too intimidating or the programs are offered during working hours. Successful programs try to reduce the barriers of money, time, fragmentation, geographic and psychological remoteness that make heavy demands on those with limited energy and organizational skills. Successful programs persevere to reach the perplexed, discouraged and ambivalent – the hardest to reach, who are often the ones who would benefit most. There must be strategies to ensure supports/services actually reach the designated groups.

On the other hand, sometimes successful programs for high risk families develop lengthy waiting lists. It is important to avoid this situation. If this happens, it is necessary to quickly identify additional partners who can provide resources to eliminate the waiting list.

3. Involve parents/youth/ community leaders: See bibliography: 4, 37, 45, 84, 85, 87, 92, 94, 96, 100, 102, 114, 117, 118, 122

Effective supports/services include parents, youth and other community leaders in meaningful, significant decision-making from the very earliest stages of planning. If parents, youth and community leaders are involved with service providers right from the very start, the initial planning period goes a little slowly, until people become accustomed to working with each other.

With this type of joint planning the activities and programs are strongly supported and attended by the designated groups for whom they are intended. If planners and service providers exclude participants and community leaders until **after** draft plans and frameworks are developed, there is almost always a long period of distrust and resistance, as plans go through a necessary re-alignment to meet community and client needs.

Parents and youth cannot be used as token representatives. "Tokens" rarely have the courage to contradict professionals. Meaningful, significant involvement of parents and youth in decision-making usually means these participants make up half or more of the planning groups and committees.

Parents, youth and clients must also be involved in "real decision-making," not just advising. They need to be involved in setting and approving budgets, preparing job descriptions, sitting on hiring panels and making decisions about the types of services and the level of service provision. When parents, youth, clients and community members have the opportunity to participate in this level of decision-making, there are plenty of volunteers who make time to become committed planners.

A successful volunteer program requires careful planning and investments of time and money. This requires a significant level of effort in screening, recruiting, matching, training, ongoing support, monitoring and feedback. Although supporting parents and youth in decision-making is neither no-cost nor low maintenance, the benefits of a high-quality volunteer program are extraordinary.

4. Tailor to the local community:

See bibliography: 4, 37, 45, 59, 84, 85, 86, 92, 94, 95, 100, 102, 114, 116, 117, 118, 122

The effective supports/services are tailored to the local needs and desires of the community. This applies to what is provided, what is provided first, and how services are delivered.

For example, although the nine effective supports/services have been shown to be effective in the research literature, there is little available research evidence as to whether these are effective with specific ethno-cultural or Aboriginal groups. Therefore, if supports/services are to be located in areas where participants have a strong ethno-cultural or Aboriginal influence, it will be important to jointly examine the recommended services with community leaders, parents and service providers to determine whether these supports/services are appropriate.

Some communities, agencies and parents will have strong opinions on what types of services need to be implemented first. It will be important that this decision is resolved to people's mutual satisfaction, even if it takes a period of time for consensus to develop.

Another way that programs must be tailored to local communities revolves around how supports/services are provided. For example, in some locations the school or school board may take the leadership role, whereas in other locations it may be an agency or a community service club. This example is played out many times, as each prevention, early intervention and developmental support/service is planned. Implementation must be tailored to the needs and desires of the community.

5. Integrate supports/services:

See bibliography: 4, 37, 86, 92, 94, 100, 102, 114, 117, 118, 122

Effective programs do not operate in an isolated, independent fashion. Effective prevention, early intervention and developmental support/service systems have integrated service planning, resources and implementation. The service providers meet regularly, with parents and community residents, to develop and implement supports/services where resources are blended, and where services are unduplicated. Integration of services includes joint planning, common goals and objectives as well as shared staff, training and facilities. Effective supports/services make integration an important part of service delivery.

As noted in the *Making Services Work for People* document, the ministry encourages local planning initiatives to include services of other funders in mechanisms to coordinate or integrate information, access and assessment. The Ministry of Community and Social Services is expected to facilitate and support local efforts to include other services in these ways. This also applies to prevention, early intervention and developmental supports/services provided through reinvestment.

6. Create linkages and partnerships: See bibliography: 4, 37, 86, 92, 94, 100, 102, 114, 116, 117, 122

MCSS cannot build an effective investment supports/services system without strong linkages and partnerships with other government and non-government supports and services. Many of these supports/services are already in existence (e.g., schools, public health, housing authorities, programs that deal with violence against women, substance abuse programs, police, libraries, faith community, service clubs, non-profits such as YMCA/YWCA, Boys and Girls Clubs, etc.). More than 20 different types of services are listed in Appendix B. Many of these make significant contributions to the well-being of children and youth.

If prevention, early intervention and development supports services system partnerships are successful, they will:

- avoid duplication and unnecessary competition among supports/services.
- avoid dependence on government to provide services that are more effectively provided by communities and families.

To be successful, it is also crucial for the prevention, early intervention and developmental supports/services systems to have excellent linkages with treatment services and services that meet a family's basic needs. People with great needs for treatment will always come to the attention of prevention and early intervention programs. It is not possible for prevention and early intervention programs to be successful without good linkages to treatment programs and other essential services.

Planning

MCSS' core functions require local MCSS-funded systems of services to provide some prevention, early intervention and developmental supports/services. The reinvestment strategy requires an increase in these investment supports/services.

The reinvestment strategy is intended to foster and build planning and delivery coalitions needed in each area to achieve innovative, integrated, effective supports/services. The Ministry recognizes it cannot implement effective prevention, early intervention and developmental supports/services with only its own resources.

The Ministry's efforts must be planned with, for and around other national, provincial, municipal, corporate and private efforts and contributions.

Planning for services provided through reinvestment funds must be part of the larger planning for *Making Services Work for People.* The reinvestment services planning can be done by the overall local advisory group, or may be a separate subcommittee or process.

It is important that links with education, health, municipalities, as well as other important players be made at the planning level.

For example:

- Under the Healthy Babies, Healthy Children initiative, public health units will work with health and social service providers to ensure that all pregnant women and families with newborns are screened, in-home assessments are conducted for those at risk, home visits by lay home visitors are provided for those at high risk where appropriate, and linkages are made to community. Public health units should be included in all planning for prevention, early intervention and developmental supports for families with young children.

- The Ministry of Health's new Preschool Speech and Language initiative, as well as the Ministry of Community and Social Services' Infant Development Program, should be part of the overall reinvestment in early intervention and developmental supports/services for families with young children.

- The Better Beginnings, Better Futures programs and the federal Community Action Program for Children, prenatal nutrition and Aboriginal Headstart often meet the criteria of effective services. They have much to contribute in "lessons learned" for prevention, early intervention and developmental supports. It will be important to include these organizations in planning for reinvestment.

- There are numerous organizations, such as Variety Club, Easter Seals, Kiwanis, United Way's "Success by Six", or the YMCA/YWCA, as well as municipalities that have important contributions to make in planning reinvestment services. The contributions from organizations such as these will vary from location to location, but when such groups are active, they should be invited to assist in the planning for reinvestment.

Planning activities

There are two planning activities that build the foundation of the reinvestment strategy:

1. Conduct environmental scan

2. Identify local reinvestment priorities

1. Conduct environmental scan

As part of the larger reshaping efforts, each Area Office will ensure that local planning processes will conduct an environmental scan of the catchment area of the local system of services. An environmental scan consists of consolidating two types of information across the catchment area:

Risk assessment: compiling information on risk factors and related socio-demographic information

Capacity assessment: compiling information on supports and services available to children, youth and families.

Risk assessment consists of literally mapping out the locations in the catchment area that have unusually high rates of risk factors and related socio-demographic information. The capacity assessment consists of mapping out all of the services and supports to children, youth, consumers and families in the catchment area. If the risk assessment maps and the capacity assessment maps are copied onto transparencies, it is easy to overlay them on an overhead projector to show whether supports/services are reaching the groups of children and youth designated for reinvestment.

The environmental scan consists of four steps:

- Select a few preliminary locations.
- Prepare comprehensive risk and capacity information.
- Assess community readiness.
- Determine priority areas for implementation.

A. Select a few preliminary locations.

The initial step in the environmental scan is for each local planning group to select a modest number of key geographic locations to begin the reinvestment supports/services. Local planners can begin the environmental scan by seeking information from people who know thoroughly the location of children and youth in the groups selected for reinvestment. The areas most in need of prevention, early intervention and developmental supports/services will be well known to MCSS Area Offices, child welfare and children's mental health agencies, support groups for people with developmental disabilities, municipal planners, police, teachers, real estate agents and most especially to the people who live in those areas. Even in rural areas, there are certain locations where there is near-universal agreement that the problems are great.

B. Prepare comprehensive risk and capacity information.

For each of the preliminary locations, compile information that will help determine the final location(s) of the reinvestment supports/services.

Appendix A is a list of about 40 indicators of risk, socio-demographic factors, and service use information. Be aware that there are problems with all of the indicators mentioned in this appendix. Very high-risk families are the most under-reported in all social indicators from census counts to police statistics to mental health service use information. It is important to remember that social indicators are imperfect. They are a necessary, but not sufficient, part of data collection.

Appendix B is a preliminary list of services that can be used to begin a capacity assessment of supports, services and resources to families with young children. The list includes schools, child care resources, libraries, programs run by non-government funded organizations such as Scouts, Boys and Girls Clubs, YMCA/YWCA, and those run privately or through the faith community. The goal is to locate <u>all</u> supports and services that contribute to healthy child development, and quality of life for all the children and youth in the reinvestment groups.

At first, completing an environmental scan may look intimidating. But keep the following in mind:

- **It is not crucial to obtain every piece of information** suggested in Appendix A and Appendix B. Just obtain what is readily available; next year try to increase the scope and reliability of the data.

- **Most information is readily available** through MCSS, Statistics Canada, Indian and Northern Affairs Canada, boards of education, public health units, regional municipality planning offices and the district health councils. Many of these organizations have already purchased data tapes, or adapted available datasets to local postal codes or census tracts. If preliminary work has not been completed, other planning organizations may be interested in providing resources for this exercise.

- **Pulling this information together has a strong positive influence on local planning**. These indicators provide a picture of children, youth, clients and community needs and capacities which provides additional assurance to planners that their priorities and directions are appropriate.

- **Make use of qualified individuals**. There are many academics in colleges and universities throughout the province who can be very helpful in conducting the environmental scan. Retired academics and municipal and industrial planners may enjoy making this a community service contribution. Look for a person or small group of persons who are excited by and capable of taking on this exercise.

C. Assess community readiness.

Historically, the Ministry has experience working with some communities and groups that would meet any person's definition of high risk, but are pre-occupied with larger, very demanding issues (for example, a community or groups where there have been revelations of extensive sexual abuse involving a large group of adults or children). A community or group, de-stabilized by this type of consuming problem, does not have time or energy to institute a major prevention, early intervention and developmental supports/services system. If such communities or groups are identified in the environmental scan, it is more important for Ministry agencies and staff to temporarily assist the community to work through the larger issue than to initiate an investment services system. Only after resolving these issues will the community be able to provide the energy required to develop an effective prevention, early intervention and developmental supports/services system. Working through these issues may create the capacity and interest to deal with reinvestment services.

D. Determine priority areas for implementation.

Planners should be aware that determining priority areas for reinvestment is not a science. The analyses of risk and capacity data will provide some basis for understanding the needs of each location, and the differences among them. Determining priority areas for reinvestment is not merely a matter of adding up the worst risk indicators, nor the areas with the densest risks, nor the areas of fewest services. For example, a potential area for reinvestment may not have the highest rate of poverty, but

there may be high rates of alcoholism and family violence. Each local planning process can anticipate some very difficult decisions on where to locate the initial reinvestment supports/services.

2. Identify local reinvestment priorities

Once the local planning process determines the priority locations for reinvestment, the final step is to decide which of the effective supports/services to establish first. Based on the analysis of the information collected in the environmental scan, areas will have an indication of the priority for developing new, or enhancing existing supports within the local area.

Each local system of service must develop a plan which increases the level of resources applied to *some* prevention, early intervention and developmental supports for the designated groups of children and youth.

As a final step in the planning process, Area Offices will review all the local service plans to assign final priorities about which of the identified groups and which of the effective supports/services will receive enhanced resources.

In some areas it will be appropriate to move ahead on all supports/services right away, because the supports/services currently in place are close to meeting the required system features. In other catchment areas it will be better to initially select only one or two effective supports/services, and make sure each has all key system features in place before expanding to include the other types of effective supports/services.

The local priorities for effective supports/services will also depend on how agreeable the existing supports/services are to altering their approaches to become more effective. Different groups, such as municipalities, school boards, hospitals, local service providers and planning groups, as well as parents, youth and clients, will look at the same data and see different implications for prevention, early intervention and developmental supports/services. They also have different mandates and regulations, which affect their own priorities for service provision. Finally, both MCSS and non-MCSS organizations may have different views on the value of the key system features. Area Offices can anticipate a period of negotiation with existing services before the final priorities for reinvestment are established.

Principles of process

The Ministry supports four principles of process in planning for the reinvestment strategy:

- Build on existing resources
- Invest strategically
- Focus on designated groups
- Allow time for development.

1. Build on existing resources

The strategy for reinvestment is to build on existing supports/services that already meet the requirements of what is known to be effective, or can be reshaped to become more effective. The following are examples:

- If the effective service is missing some of the key system features, the ministry could provide funds to support integration of services, involvement of parents, youth and consumers in decision-making or other important aspects of implementing key system features.

- If, for example, the local planning group identifies recreation as its first priority for prevention, early intervention or developmental supports for children, the Ministry would try to improve access to existing recreation programs (for example: Little League, bowling, summer day camp, etc.). The enhancement could include Ministry support for specialized training to prepare coaches for young children with developmental delays or young mothers with low income; or it could include funds for transportation, so programs reach high-risk children who could not ordinarily access the programs; or it could include equipment purchases or resources to meet the needs of MCSS reinvestment groups.

In summary, it is preferred that MCSS reinvestment funds be used to enhance or expand existing services to become more effective.

The Ministry role in reinvestment is not limited to funding. A key role will be facilitation, or bringing partners together to determine the variety of appropriate ways to support a program. Examples could include:

- Working with community colleges to change the curriculum so it includes training coaches for children and youth with special needs.

- Linking with local transportation committees regarding transportation to prevention/early intervention programs.

If there is no existing type of the desired effective service already in place, the ministry will first try to broker a partnership with other potential key cofunders. These partners could include service clubs or community groups (such as Kiwanis Club, Big Brothers/Sisters, etc.), schools and health services, and other federal and provincial services. The Ministry will only start an effective program from scratch with sole funding responsibility if 1) the local planning group indicates it is crucial, and 2) there is absolutely no other organization willing to assume any kind of a partnership role.

Building on existing resources also means avoiding duplication of service. There are numerous examples of both home visiting and parent support where service providers in high risk areas are duplicating services. Building on existing services must go beyond simply clarifying how to keep each similar service unique and operating; it includes reducing duplication and increasing integration of some services.

2. Invest strategically

Current levels of Ministry-funded investment supports/services are inconsistent, as a result of:

- inflexibility of legislation and policy to meet local needs,

- uneven resources, and

- local innovation and priority setting.

The overall uneven distribution of prevention, early intervention and developmental supports is also due to services provided by other funders such as other ministries (health, housing, education and recreation), health units and school boards, and the many services provided or sponsored by the federal government, non-profit service organizations and faith communities.

Once the environmental scan is completed, and the local planning group is aware of the areas of high need and low service provision, the Ministry will make strategic decisions on where to place its initial investments. High-risk communities that currently have large prevention programs in place, and that meet the criteria of being effective, will not be considered a priority for MCSS reinvestment, even if MCSS does not currently contribute to the funding of that prevention program. MCSS funding decisions for effective prevention, early intervention and developmental supports/services will be based on what is already in place, regardless of whether MCSS funds it or not.

3. Focus on designated groups

There will be pressure on local planning groups to expand the focus beyond the designated groups the Ministry has selected for reinvestment. There are a number of important high-risk groups that the Ministry has not designated for reinvestment, and advocates for those groups will make strong efforts to address those needs locally. The Ministry supports investment services generally through its core services.

The reinvestment strategy, however, is a specific approach for designated groups, and its implementation of effective supports/services and key system features will be measured. Individual agencies can respond to general community requests for investment supports to address needs for groups that are outside the reinvestment strategy. It is important to keep the focus of reinvestment on the designated groups, supports/services and key system features selected by MCSS, because there will be measures of compliance in place.

4. Allow time for development

It will take time to fulfill the vision of the reinvestment strategy. Integration of services, involvement of parents, youth and clients in decision-making and outreach to the designated groups are challenging to implement. They require new relationships and new roles. The first two years of implementation may require laborious, persistent negotiations. Ministry leadership at the Area level should acknowledge the friction that comes with change, and provide a base of understanding to service providers that dissent is a normal part of system development.

Appendix A

Risk assessment: risk factors, socio-demographic factors and service use

The following information is often already available from school boards, regional municipal planning bodies, band councils or district health councils. If no other planning organization has prepared any of the following material, then consider joining forces with them to obtain the information.

TRENDS: It may seem a big task just to obtain the most current year's information. However, there is a definite advantage to obtaining 10-year trend information (five years back and five years forward), whenever possible. If the population of children is rapidly increasing or decreasing in a location, this should strongly influence decisions for reinvestment. This applies to almost every indicator listed below. During the initial year of planning it may be necessary to limit data collection to current available information to meet timeframes. However, it is important for all planning groups to move toward gathering information on trends of risk factors and service provision.

Demographic information:

1. Population and population estimates of children and youth, birth to 16 years old.

2. School boards 1995/96 enrolments and estimates of enrolment in junior and senior kindergarten.

3. Actual number of children, birth to six years old, with health limitations. (Health Activity Limitation (HAL) Census data)

4. Estimated number of children, birth to six years old, with a developmental disability. (MCSS Developmental Services Branch)

5. Number of Aboriginal children and youth, birth to 16 years old. (Indian and Northern Affairs Canada for status Indians, on- and off-reserve; Statistics Canada for children of Aboriginal descent.)

   NOTE: Each year, the federal Department of Indian and Northern Affairs Canada publishes statistics relating Aboriginal children to various conditions of risk (e.g., infant mortality, kindergarten enrolment, housing, etc.). The document is Basic Departmental Data, and can be ordered by fax: 613 - 953 - 6010.

Service system data:

1. Enrolment of children from birth to four years in formal child care programs and estimated numbers in informal child care programs/activities.

2. Mothers and expectant mothers receiving social assistance. (MCSS)

3. Children and youth living in a family receiving social assistance. (MCSS and Statistics Canada)

4. Children and youth living in subsidized housing. (Statistics Canada)

5. Children and youth of mentally ill parents. (MOH adult mental health programs.)

6. Children and youth of incarcerated parents. (This is most important for areas near prisons. Information provided by the prison.)

7. Children and youth of developmentally-disabled parents. (Information from CAS, CMHC, and OACL.)

8. Children and youth of substance-abusing parents. (Information from hospitals, ARF and MOH programs.)

9. Number of open CAS cases.

10. Number of children and youth in CAS care.

Other Risk Factors:

Unemployment rate (Statistics Canada)
Percentage of the labour force that was unemployed.

Families living in poverty (Statistics Canada)
Proportion of families with income under the poverty line.

Low birthweight rate (public health unit)
Number of live births under 2,500 grams per 1,000 live births.
Number of live births under 1,500 grams per 1,000 live births.

Preterm birth rate (public health unit)
Number of live births before 37 weeks gestation.

Perinatal mortality rate (public health unit)
Sum of stillbirths and deaths of live born infants, regardless of weight up to 7 days of life per 1,000 total births.

Infant mortality rate (public health unit)
Number of infant deaths under one year of age per 1,000 live births.

Lone parent family rate (Statistics Canada)
Proportion of families that are single parent families with children under 18 years of age.

Out-of-wedlock birth rate (Statistics Canada)
Number of births to unmarried mothers per 100 live births.

Ratio of births to teen mothers (public health unit)
Number of pregnancies per 1,000 to mothers under 20 years of age. If appropriate, note the rate for each age specific cohort of teen mothers.

Large families (Statistics Canada)
Number of families with five or more children living at home per 1,000 families with children at home.

Over-crowded housing (Statistics Canada)
Number of families with fewer rooms than there are household members.

Educational attainment (Statistics Canada)
Number of adults with less than a Grade 9 education per 100 persons age 15 years or older.

Mother's low education (Statistics Canada)
Number of female parents or guardians of all families who have completed no more than Grade 8 education.

School drop-out rate (school board)
Number of secondary school drop-outs (Grade 9 - 12) per equivalent school age population.

Poor school performance (school board)

- Number of children, per 1,000 children, who have ever received full-time remedial education.

- Number of children, per 1,000 children, who have ever failed one or more grades.

Immigration rate (Statistics Canada)
Number per 1,000 population of immigrants from outside Canada who have not lived in Canada for more than five years.

Mother tongue not English or French (Statistics Canada)
Number per 1,000 population who speak a language other than English or French as their mother tongue.

Aboriginal population (Statistics Canada; band councils)
Number of Aboriginals per 1,000 population.

Youth crime rate (police department)
Number of youth charged per 1,000 population between the ages of 12 - 19 years.

Domestic Violence (police department)

- Any local surveys which document the percentage of parents who report hitting or being hit by a spouse/partner.

- Charges laid by local police for domestic violence.

Alcoholism rate (hospital records)
Number of hospital discharges following treatment for alcoholism, per 1,000 population.

Alcohol psychosis rate (hospital records)
Number of hospital discharges following treatment for alcohol psychosis per 1,000 population.

Suicide rate (hospital records)
Number of suicides per 1,000 population. If appropriate, note the rate for each age specific cohort of teens.

Appendix B

Capacity assessment: community supports/services

- Family relief/respite programs
- Child care centres
- Elementary schools (some with project funds for nutrition, recreation or child health)
- Public health units (may have additional fund sources to deliver programs)
- Community health centre (may have additional funds to deliver programs)
- Some hospitals deliver community-based services
- Infant development programs
- Behaviour management supports/services
- Child welfare and children's mental health programs, with and without special prevention, early intervention and developmental programs
- Housing authority programs, such as breakfast clubs and tenant support groups
- Municipal recreation programs
- Violence against women programs that also provide services to children
- Native Friendship Centre programs for children and families, with and without additional federal program funding
- Mental health clinics providing some special parenting programs
- Substance abuse programs for parents and youth
- Police/community relations programs
- Libraries, which may provide play group, drop-in and breakfast programs
- Faith community programs, which may provide a variety of prevention, early intervention and developmental programs
- Service club programs, such as Lion's Quest International early elementary school social skills development programs
- Non-profit service organizations such as YWCA/YMCA, Family Services Association, Scouts, Big Brothers/Sisters, Boys & Girls Clubs
- Ethno-specific weekend and evening education and recreation programs

Appendix C

Reference guide for the *Reinvestment Strategy for Children and Youth*

Reinvestment Groups	9 Types Effective Supports and Services	6 Key System Features	2 Planning Activities	4 Principles of Process	Community Partners
Prevention: Families with children under six in poverty neighbourhoods Low income mothers, and expectant mothers, under 20 w/ their children Children and youth whose parents have developmental disabilities Children and youth whose parents have serious substance abuse problems Children and youth whose parents have mental disorders Children and youth whose parents have in prison Children and youth in families w/ violence or child protection services Early intervention and developmental: Children under 6 with developmental delays. Children under 6 with aggressive behaviour. Children under 6 with early emotional or behavioural disorder.	Home visiting Flexible continuum child care Supports to primary schools Family support, education and community development Mentoring Support groups Supports to stay in school Recreation Casework and clinical practices	Holistic Ensure access Involve parents, youth and community leaders in decision-making Tailor to the local community Integrate supports and services Create linkages and partnerships	Conduct environmental scan Identify local priorities	Build on existing resources Invest strategically Focus on designated groups Allow time for development	To be determined locally

Appendix D

Example of community reinvestment plan: children and youth

Planning Group: identifies the local priorities from among the groups designated for reinvestment.	**Planning Group: Selects the types of effective supports/ services for each reinvestment group**	**Planning Group: determines what key system features must be enhanced for each type of effective service**	**Planning Group: determines which planning activity is required**	**Planning Groups: follows the principles of process**	**Planning Group: determines appropriate community partners**
Early Intervention and Developmental: 1. Children under 6 with developmental delays 2. Children under 6 with aggressive behaviour 3. Children under 6 with early emotional or behavioural problems	Specialized supports to integrated child care	Ensure access Involve parents in planning and implementation Integrate with other supports/services	Environmental scan of young children and existing resources/ services	Build on existing resources Invest strategically	Kiwanis Public Health Municipal child care
Prevention: 4. Youth whose parents have serious problems with substance abuse	Support group of youth with similar problems Mentoring Supports to stay in school Recreation	Holistic Ensure access Involve youth in planning and implementation	Determine priority locations for implementation	Focus on designated group Allow time for development	YMCA Scouts ARF School Board(s)

Bibliography

***Reinvestment Strategy for Children and Youth* prevention, early intervention and developmental supports/services**

Recommended background readings

1. Andrews, D.A., Hoge, R.D., & Leschied,Q.W. (1992). Review of the Profile, Classification and Treatment Literature with Young Offenders: A Social-Psychological Approach. Toronto, Ontario: Ministry of Community and Social Services.

2. Andrews, D., Bonta, J., & Hoge, R.D. (1990). "Classification for Effective Rehabilitation: Rediscovering Psychology," Criminal Justice and Behavior, Vol. 17, pp. 19 - 52.

3. Andrews, D., Zinger, I., Hoge, R.D., Bonta, J., Gendreau, P., & Allen, F.T., (1990). "Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-Analysis," Criminology, Vol. 28, pp. 369 - 404.

4. Annie E. Casey Foundation, The Path of Most Resistance: Reflections on Lessons Learned from New Futures, Baltimore, MD: The Annie E. Casey Foundation.

5. Anthony, E.J., and B.J. Cohler (eds.), (1987), The Invulnerable Child, New York: The Guilford Press.

6. Bagley, C., Thurston, W., Decreasing Child Sexual Abuse, paper commissioned by the National Forum on Health, Ottawa, 1997 (in press).

7. Baldwin, A.L., C. Baldwin and R. E. Cole, "Stress-resistant Families and Stress-resistant Children," in Risk and Protective Factors in the Development of Psychopathology, edited by J. Rolf, A. Master, D. Cicchetti et al., 1990, Cambridge: Cambridge University Press.

8. Ballantyne, M., and L. Raymond, Effective Strategies for Adolescents at Risk of Out-of-Home Placement, Ontario Association of Children's Aid Societies, September 1996 (in press).

9. Barnett, W.W., "Benefit-Cost Analysis of Preschool Education: Findings from a 25 Year Follow-Up," American Journal of Orthopsychiatry, 63.

10. Bennett, K. and Offord, D., Schools, Mental Health and Life Quality, paper commissioned by the National Forum on Health, Ottawa, 1997 (in press).

11. Bertrand, J., Enriching the Preschool Experiences of Children, paper commissioned by the National Forum on Health, Ottawa, 1997 (in press).

12. Bloom, D., V. Fellerath, D. Long, and R.G. Wood, LEAP: Interim Findings on a Welfare Initiative to Improve School Attendance Among Teenage Parents, and Executive Summary of Ohio's Learning, Earning and Parenting Program, Columbus, OH: Manpower Demonstration Research Corporation, May 1993.

13. Breakey, G., and Pratt, B. (1991). "Healthy Growth for Hawaii's "Healthy Start:" Towards a Systematic Statewide Approach to the Prevention of Child Abuse and Neglect," Zero to Three, 11(4), pp. 16 - 22.

14. British Columbia, Report of the Aboriginal Committee, Community Panel, Family and Children's Services, Legislation Review in British Columbia, Liberating Our Children, Liberating Our Nations, October 1992.

15. Bryant, D. and Ramey, C. (1987). "An Analysis of the Effectiveness of Early Intervention Programs for Environmentally At-Risk Children," in M.J. Guralnick and F.C. Bennett (eds.), The Effectiveness of Early Intervention for At-Risk and Handicapped Children, Toronto: Harcourt, Brace, Jovanovich, pp. 33 - 78.

16. Canada, Health Canada, grant from the Community Action Program for Children segment of the Brighter Futures Program to the Premier's Council in Support of Alberta's Families, Overview of Effective Approaches in Working with Families at Risk, 1993.

17. Canada, Health Canada, National Clearinghouse on Family Violence, An Examination of the Association Between Histories of Maltreatment and Adolescent Risk Behaviours, report prepared by Ian G. Manion, and Susan Kay Wilson, 1995.

18. Canada, Health Canada, National Clearinghouse on Family Violence, Wife Abuse - The Impact on Children, April, 1996 (revised).

19. Canada, Health Canada, National Forum on Health, "What Determines Health?" September, 1996 (Summaries of a Series of Papers on the Determinants of Health, Commissioned by the National Forum on Health), Ottawa.

20. Canada, Health Canada, National Forum on Health, Volume I: "Canada Health Action: Building on the Legacy: Final Report of the National Forum on Health," Ottawa, February, 1997.

21. Canada, Health Canada, National Forum on Health, Volume II: "Canada Health Action: Building on the Legacy, Synthesis Reports and Issues Papers," Ottawa, February, 1997.

22. Canada, Health Canada, report prepared for the Childhood and Youth Division, Aboriginal Head Start, Literature Review: A Reference for Aboriginal Head Start Project Operatoea, prepared by Sheila Clark & Associates.

23. Canada, Human Resources Development Canada and Statistics Canada, Growing Up in Canada: National Longitudinal Survey of Children and Youth, Ottawa: Statistics Canada, 1996.

24. Canadian Council on Social Development, The Progress of Canada's Children: 1996, prepared by Katherine Scott and David Ross, 1996.

25. Canadian Institute for Advanced Research, Program in Human Development, Reprint Series, Paper No. 3, "Relation Between Economic Disadvantage and Psychosocial Morbidity in Children," Ellen L. Lipman, Dan R. Offord, Michael H. Boyle (7 pages), 179 John Street, Suite 701, Toronto, Ontario.

26. Canadian Institute for Advanced Research, Program in Human Development, Working Paper No. 1, "Habits of Mind: Developmental Diversity in Competence and Coping," Daniel P. Keating (20 pages), 179 John Street, Suite 701, Toronto, Ontario.

27. Canadian Institute for Advanced Research, Program in Human Development, Working Paper No. 2, "The Learning Society in the Information Age," Daniel Keating (32 pages), 179 John Street, Suite 701, Toronto, Ontario.

28. Canadian Institute for Advanced Research, Program in Human Development, Working Paper No. 5, "The National Forum on Family Security - Social Economic Factors and Human Development," Daniel Keating and J. Fraser Mustard (24 pages), 179 John Street, Suite 701, Toronto, Ontario.

29. Canadian Institute for Advanced Research, Hertzman, C. and M. Wiens, "A Source Document of Longitudinal Research and Specific Intervention Programs outside of Canada," Working Paper No. 3, 179 John Street, Suite 701, Toronto, Ontario, March 1994.

30. Canadian Institute for Advanced Research, Hertzman, C, and M. Wiens, "Surveys and Longitudinal Research in Canada- A Source Document of Relevant Studies," Working Paper No. 3, 179 John Street, Suite 701, Toronto, Ontario, March 1994.

31. Canadian Institute for Advanced Research, Hertzman, C. and M. Wiens, "Child Development and Long-Term Outcomes: A Population Health Perspective and Summary of Successful Interventions," Working Paper No. 1., 179 John Street, Suite 701, Toronto, Ontario, March 1994.

32. Canadian Institute for Advanced Research, Population Health Working Paper No. 8, "Where are the Differences Which Make a Difference?" Clyde Hertzman (35 pages), 179 John Street, Suite 701, Toronto, Ontario.

33. Canadian Institute for Advanced Research, Population Health Working Paper No. 20, "Why are Some People Healthy and Some People Not?" Robert G. Evans (30 pages), 179 John Street, Suite 701, Toronto, Ontario.

34. Canadian Institute for Advanced Research, Population Health Working Paper No. 39, "Health, Hierarchy and Hominids: Biological Correlates of the Socio-Economic Gradient in Health," Robert G. Evans (34 pages), 179 John Street, Suite 701, Toronto, Ontario.

35. Canadian Institute for Advanced Research, Program in Economic Growth and Policy Working Paper No. 31, "Economic Growth and Investment in Children," Paul Romer (25 pages), 179 John Street, Suite 701, Toronto, Ontario.

36. Canadian Institute of Child Health, The Health of Canada's Children, 2nd edition, prepared by Hanvey, L., Avard, D., Graham, I., Underwood, K., Campbell, J., Kelly, C., in Ottawa: CICH, 1994.

37. Canadian Parks/Recreation Association, Youth at Risk: Impact and Benefits of Physical Activity and Recreation on Canadian Youth-at-risk, a discussion paper, Gloucester, Ontario: Canadian Parks/Recreation Association.

38. Carmichael, David, Building a Solid Foundation for Sporting Success: A Guide for Parents of Young Children, North York, Ontario: Active Health Links, Inc., 1994.

39. Carmichael, David, Helping Young People Make the Active Choice: Considerations for Recreation Leaders, North York, Ontario: Parks and Recreation Federation of Ontario, 1992.

40. Carmichael, David, Margaret Good, and Janet Grainger, Sportability: Teacher/Instructor Manual, Willowdale, Ontario: Ontario Physical and Health Education Association, 1990.

41. Carmichael, David and Madelaine Currelly, Movability, Willowdale, Ontario: Ontario Physical and Health Education Association, 1992.

42. Carnegie Corporation of New York, "Starting Points: Meeting the Needs of Our Youngest Children," August 1994.

43. Ciliska, D., Hayward, S., Thomas, H., Mitchell, A., Dobbins, M., Underwood, J., Rafael, A., Martin, E., (1994), The Effectiveness of Home Visiting as a Delivery Strategy for Public Health Nursing Interventions - A Systematic Overview, Working Paper 94 - 7, Quality of Nursing Worklife Research Unit, University of Toronto/McMaster University.

44. Conrad, M., and C. Hammen, "Protective and Resource Factors in High and Low Risk Children: a Comparison of Children with Unipolar, Bipolar, Medically Ill and Normal Mothers," Development and Psychopathology, 5: 593 - 607.

45. Cunningham, Charles E., "Parent Training Programs for Families of Children with Disruptive Behaviour," Sparrow Lake Inserts, No. 2, Spring 1994.

46. Cunningham, C., Bremner, R. And Boyle, M. (1995) "Large Group Community-based Parenting Programs for Families of Preschoolers at Risk for Disruptive Behavior Disorders: Utilization, Cost Effective and Outcome," Journal of Child Psychology and Psychiatry, 36(7), 1141 - 1159.

47. Cynader, M., "Mechanisms of Brain Development and Their Role in Health and Well-Being," Daedalus, Journal of the American Academy of Arts and Sciences, Fall, 1994, pp. 155 - 165.

48. Dadd, M., Schwartz, S. And Sanders, M. (1987), "Marital Discord and Treatment Outcome in Behavioral Treatment of Child Conduct Disorders," Journal of Consulting and Clinical Psychology, 55, 396 - 403.

49. Feldman, M. (1994). "Parenting Education for Parents with Intellectual Disabilities: A Review of Outcome Studies," Research in Developmental Disabilties, Vol. 15, No. 4, pp. 299 - 332.

50. Feldman, M. and Walton-Allen, N. (1997). "Effects of Maternal Mental Retardation and Poverty on Intellectual, Academic, and Behavioral Status of School-Age Children," American Journal on Mental Retardation, Vol. 101, No. 4., pp. 352 - 364.

51. Garbarino, J., Dubrow, N., Kostelny, K., and Pardo, C. (1992), "Resilience and coping in children at risk," Children in danger: Coping with the consequences of community violence, San Francisco: Jossey Bass Publishers, 1992.

52. Garmezy, N., "Children in Poverty: Resilience Despite Risk," Journal of Psychiatry, 56, pp. 127 - 136, 1993.

53. Garmezy, N., "Reflections and Commentary on Risk, Resilience, and Development," Chapter 1 in R. Haggerty, L. Sherrod, N. Garmezy and M. Rutter, Stress, Risk and Resilience in Children and Adolescents: Processes, Mechanisms and Interventions, Cambridge, England,: University of Cambridge Press, 1994.

54. Gottlieb, B., Strategies to Promote the Optimal Development of Canada's Youth, paper commissioned by the National Forum on Health, Ottawa, 1997(a) (in press).

55. Greenwood, Peter W., Modell, Karyn E., Rydell, C. Peter, and Chiesa, James. Diverting Children from a Life of Crime: Measuring Costs and Benefits, Santa Monica, CA: RAND, April 1996, http://www.rand.org/publications/MR/MR699.

56. Guralnick, M. and Bennett, F. (1987). "Early Intervention for At-Risk and Handicapped Children: Current and Future Perspectives," in M. Guralnick and F. Bennett (eds.), The Effectiveness of Early Intervetnion for At-Risk and Handicapped Children, Toronto: Harcourt, Brace, Jovanovich, pp. 365 - 382.

57. Guerra, N., Tolan, P., Howesman, L., Van Acker, R. And Eron, L., (1995), "Stressful Events and Individual Beliefs as Correlates of Economic Disadvantage and Aggression Among Urban Children," Journal of Consulting and Clinical Psychology, 63(4), 518 - 528.

58. Haggerty, R., L. Sherrod, N. Garmezy and M. Rutter, Stress, Risk and Resilience in Children and Adolescents: Processes, Mechanisms and Interventions, Cambridge, England,: University of Cambridge Press, 1994.

59. Halpern, R. (1993). "The Societal Context of Home Visiting and Related Services for Families in Poverty," The Future of Children, 3(3), pp. 158 - 171.

60. Hayward, S., Ciliska, D., Thomas, H., Mitchell, A., Dobins, M., Underwood, J., (in press), The Effects of Public Health Nursing Interventions in Maternal-Child Health - A Systematic Overview of Research Reviews, Quality of Nursing Worklife Research Unit, University of Toronto/McMaster University.

61. Hertzman, C., "The Lifelong Impact of Childhood Experiences: A Population Health Perspective," Daedalus, Journal of the American Academy of Arts and Sciences, Fall, 1994, pp. 167 - 179.

62. Jones, M.B. and Offord, D.R., "Participation and Sibship Size in a Skill-Development Program: A Research Note," Journal of Child Psychology and Psychiatry, 1986: 27: 109 - 116.

63. Jones, M.B. and Offord, D.R., "Reduction of Antisocial Behavior in Poor Children by Nonschool Skill-Development," Journal of Child Psychology and Psychiatry, 1989: 30: 737 - 750.

64. Kale, P. and Cole, K. (1988). "Comparison of Academic and Cognitive Programs for Young Handicapped Children," Exceptional Children, Vol. 54(5), pp. 439 - 447.

65. Kazdin, A.E., (1995), "Child, Parent and Family Predictors of Outcome in Cognitive-Behavioral Treatment of Anti-Social Children," Behaviour Research Therapy, 33(3), 271 - 281.

66. Kuno, B. (1983). "The Philadephia Study: The Impact of Preschool on Intellectual and Socioemotional Development," in the Consortium for Longitudinal Studies, As the Twig is Bent..., New Jersey: Lawrence Erlbaum Associates, pp. 333 - 376.

67. Infant Mental Health Promotion Project, Home Visiting Task Force, (1995), Report on Survey of Home Visiting Programs in Ontario.

68. Ladewig, B. H., P.O. Jessee and M. P. Strickland, "Children Held Hostage: Mother's Depressive Affect and Perceptions of Family Psychosocial Functioning," Journal of Family Issues, 13: 65 - 80.

69. Landy, Sarah, (1994), Research on Home Visiting in Early Intervention Programs: Policy Implications, for the C.M. Hincks Centre for Children's Mental Health/University of Toronto/York University.

70. Lazar, I., Darlington, R., and Associates, Lasting Effects of Early Education: A Report from the Consortium for Longitudinal Studies, Society for Research on Child Development, 47, 1982, pp. 1 - 15.

71. MacMahon, J.R., "The Psychological Benefits of Exercise and the Treatment of Delinquent Adolescents," Sports Medicine, 1990: 9(6): 344 - 351.

72. MacMillan, H.L., MacMillan, J.H., Offord, D.R., et al. "Periodic Health Examination, 1993 Update: 1. Primary Prevention of Child Maltreatment," Canadian Medical Association Journal, 1993; 148(2), pp. 151 - 163.

73. McConnell, D.; Llewellyn, G.; Bye, R. (1997). "Providing Services for Parents with Intellectual Disability: Parent Needs and Service Constraints," Journal of Intellectual & Developmental Disability, Vol. 22, No. 1, pp. 5 - 17.

74. Morrison, M.M., T. Le Blanc, Effective Services for Young Children with Conduct Problems, Ontario Association of Children's Aid Societies (in press).

75. Morrongiello, B., Preventing Unintentional Injuries Among Children, paper commissioned by the National Forum on Health, Ottawa, 1997 (in press).

76. National Crime Prevention Council of Canada, "The Determinants of Health and Children," September 1996 (12 page pamphlet)

77. National Crime Prevention Council of Canada, "Safety and Savings: Crime Prevention Through Social Development," March 1996 (8 page pamphlet)

78. National Crime Prevention Council of Canada, "Money Well Spent: Investing in Preventing Crime," September 1996 (37 page document)

79. National Crime Prevention Council of Canada, "Preventing Crime by Investing in Families: An Integrated Approach to Promote Positive Outcomes in Children," June 1996 (50 page document).

80. Offord, D. R., Last, J.M. and Barrett, P.A., "A Comparison of the School Performance, Emotional Adjustment and Skill Development of Poor and Middle-Class Children," Canadian Journal of Public Health, 1985: 76: 174 - 178.

81. Olds, D.L., Henderson, C.R., Tatelbaum, R., and Chamberlin, R.W. (1988) "Improving the Life-Course Development of Socially Disadvantaged Mothers: A Randomized Trial of Nurse Home Visitation," American Journal of Public Health, 78(11), pp. 1436 - 1445.

82. Olds, D.L., Henderson, C.R., Phelps, C., Kitzman, H., and Hands, C., (1993). "Effect of Prenatal Care and Infancy Nurse Home Visitation on Government Spending," Medical Care, 31, PP. 155 - 174.

83. Olds, D.L., and Kitzman, H. (1993). "Review of Research on Home Visiting for Pregnant women and Parents of Young Children," The Future of Children, 3(3), pp. 51 - 92.

84. Ontario, Final Report of the Aboriginal Child Care Consultation with Off-Reserve Aboriginal Peoples, prepared by the Ontario Federation of Indian Friendship Centres, Ontario Metis Aboriginal Association and the Ontario Native Women's Association for the Ministry of Community and Social Services, September 1993.

85. Ontario, First Nations in Ontario: Child Care Consultations: Summary and Recommendations, prepared by the Ontario Indian Social Services Council for the Ministry of Community and Social Services, March 7, 1994.

86. Ontario, For Generations to Come: The Time is Now: A Strategy for Aboriginal Family Healing, submitted by Sylvia Maracle and Barbara Craig to the Ministers of Women's Insures, Native Affairs, Health, and Community and Social Services, 1993.

87. Ontario, Horizons of Hope: An Empowering Journey: Youth Forum, Final Report, prepared by the Nishnawbe-Aski Nation Youth Forum on Suicide for the Ontario Ministry of Health and Health Canada, 1996.

88. Ontario, Let's Go! How to Start a Recreational Skill-Development Program in Economically Disadvantaged Communities, prepared by D.R. Offord and M. Jones, for the Ministry of Community and Social Services, Queen's Printer: 1990.

89. Ontario, Ministry of Culture, Tourism and Recreation, Recognition Criteria for Children's Recreation Services, Queen's Printer for Ontario: 1994.

90. Ontario, The Benefits of Recreation Catalogue, Parks and Recreation Ontario: 1994.

91. Ontario, Premier's Council on Health, Well-being and Social Justice, Final Report for a Grant, "Staying on Track: An Early Identification, Tracking, Intervention and Referral System for Infants, Young Children and Their Families," by Sarah Landy, Ray DeV Peters, A. Brian Allen, Faye Brooks, and Susan, Jewell, September 1993.

92. Ontario, Ministry of Community and Social Services, Better Beginnings, Better Futures: An Integrated Model of Primary Prevention of Emotional and Behavioural Problems, Naomi Rae-Grant and Carol Crill Russell, Toronto, ON: Queen's Printer for Ontario, 1990.

93. Ontario, Ministry of Community and Social Services, Better Beginnings, Better Futures, "Model, Program and Research Overview," by Ray DeV. Peters, Ph.D., and Carol Crill Russell, M.S.W., Ph.D., Queen's Printer for Ontario, 1994.

94. Ontario, Ministry of Community and Social Services, Better Beginnings, Better Futures, "1993 Lessons Learned and Description," Queen's Printer for Ontario, 1994.

95. Ontario, Ministry of Community and Social Services, Factors Related to Quality in Child Care: A Review of the Literature, prepared by Gillian Doherty, 1991.

96. Pepler, D., King, G. And Byrd, W. (1991), "A Social-Cognitively Based Social Skills Training Program for Aggressive Children," in D. Pepler and D. Rubin (eds.), The Development and Treatment of Childhood Aggression, Hilllsdale: Erlbaum, 361 - 380.

97. Peters, Ray DeV., and Robert McMahon, eds., Preventing Childhood Disorders, Substance Abuse and Delinquency, Thousand Oaks, CA: Sage: 1996.

98. Ray, N.; Rubenstein, H.; Russo, N. (1994). "Understanding the Parents Who are Mentally Retarded: Guidelines for Family Preservation Programs," Child Welfare, Vol. LXXIII, No. 6, November-December, pp. 725 - 743.

99. Ridington, J. (1989). The Only Parent in the Neighbourhood: Mothering and Women with Disabilities, Vancouver, B.C.: DAWN Canada.

100. Rivera, V. Robins & K. Kutash, "Family Preservation Services," in Components of a System of Care: What Does the Research Say?, The Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida, 1994, pp. 51 - 80.

101. Rutter, M., "Stress research: Accomplishments and Tasks Ahead," Chapter 10 in Haggerty, Robert J., Lonnie R. Sherrod, Norman Garmezy and Michael Rutter, Stress, Risk and Resilience in Children and Adolescents: Processes, Mechanisms and Interventions, Cambridge, England,: University of Cambridge Press, 1994.

102. Schorr, L., Within Our Reach: Breaking the Cycle of Disadvantage, New York: Doubleday, 1988.

103. Shah, C., M. Kahan and J. Krauser, "The health of children of low-income families," Canadian Medical Association Journal, 137: 485 - 490.

104. Simner, Marvin L., "CANSTART: A New Canadian Primary Prevention Program," Canadian Journal of School Psychology, 11(2), pp. 105 - 107.

105. Simner, Marvin L., Predicting and Preventing Early School Failure: Classroom Activities for the Preschool Child, Ottawa: Canadian Psychological Association, 1995.

106. Steinhauer, P. D., "Primary Prevention Strategies for Disadvantaged Populations," The Health Needs of Disadvantaged Children and Youth: Proceedings of the Ninth Canadian Ross Conference in Paediatrics, Canadian Paediatric Society, Montreal: Ross Laboratories, 1993, pp. 15 - 30.

107. Steinhauer, P.D., The Primary Needs of Children: A Blueprint for Effective Health Promotion at the Community Level, Toronto, ON: The Caledon Institute of Social Policy, April 1996.

108. Steinhauer, P.D., Developing Resiliency in Children From Disadvantaged Populations, paper commissioned by the National Forum on Health, Ottawa, 1997 (in press).

109. Suomi, S., "Early Stress and Adult Emotional Reactivity in Rhesus Monkeys," in The childhood environment and adult disease, Ciba Foundation Symposium 156, 1991, Chichester: Wiley.

110. Thiel, K.S., M. Weil, B. Ferleger, W. Russell, C. Jo, and A. Kwinn, California's Adolescent Family Life Program: Evaluating the Impact of Case Management Services for Pregnant and Parenting Adolescents, a final report submitted to the Maternal an Child Health Branch, California Department of Health Services, August 1990.

111. Tremblay, R.E., Pihl, R.O., Vitaro, F., and Dobkin, P.L. (1994), "Predicting Early Onset of Male Anti-Social Behaviour from Preschool Behaviour," Archives of General Psychiatry, 51, pp. 732 - 739.

112. Turner, R.J., A. Sorenson, and C.F. Grindstaff, Final Report on Teen Pregnancy: Factors Influencing Intermediate Outcomes Among Young Mothers and Their Children, Toronto: Department of Sociology, March 1994.

113. United States, General Accounting Office. (1990). Home Visiting: A Promising Early Intervention Strategy for At-Risk Families. Washington, D.C.: GAO. GAO/HRD - 90 - 83.

114. United States, National Centre for Clinical Infant Programs, Maternal and Child Health Bureau, Promoting Success in Zero to Three Services: A Case Study of Six Community Service Systems, 1993.

115. United Way of America, Promising Prevention Programs for Children, report prepared by Freya L. Sonenstein, Leighton Ku, Jason Juffras, and Barbara Cohen of the Urban Institute, Washington, D.C.: United Way of America, March, 1991.

116. United Way of America, Standards for Success: Building Community Supports for America's Children, Alexandria, VA: United Way of America, 1993.

117. Weiss, H.B. (1993). "Home Visits: Necessary, But Not Sufficient," The Future of Children: Home Visiting, 3(3), pp. 51 - 92.

118. Weissbourd, B. (1993). "Family Support Programs," in C. Zeanah (ed.), Handbook of Infant Mental Health. New York: the Guilford Press.

119. Werner, E., (1989), "Children of Garden Island," Scientific American, 260, 106 - 111.

120. Werner, E., "High-Risk Children in Young Adulthood: A Longitudinal Study from Birth to 32 Years," American Journal of Orthopsychiatry, vol. 59, No. 1, January 1989.

121. Werner, E., and R. Smith, (1992), Overcoming the odds: High risk children from birth to adulthood, New York: Cornell University Press.

122. W.K. Kellog Foundation, "Family and Neighbourhood Models: Summary Report,"

123. Wolfe, D., Prevention of Child Abuse and Neglect, paper commissioned by the National Forum on Health, Ottawa, 1997 (in press).

124. Wyman, P.A., et al., "Developmental and Family Milieu Correlates of Resilience in Urban Children who have Experienced Major Life Stresses," American Journal of Community Psychology, 1991, 19: 405 - 426.

125. Zayed, J., Lefebvre, L., Environmental Health: From Concept to Reality, paper commissioned by the National Forum on Health, Ottawa, 1997 (in press).

126. Zigler, E., Taussig, C., Black, K., "Early Childhood Intervention: A Promising Preventative for Juvenile Delinquency," American Psychologist, Vol. 47, No. 8, August, 1992.